# Psychiatric and Behavioral Disorders

## Reactions to Illness/Injury

- Realistic Fears
- General Anxiety
  - Restlessness, sleeplessness, irritability
  - Seeking of attention/reassurance
  - Can mimic variety of physiologic problems

## Reactions to Illness/Injury

- Regression
  - Behavior in child-like manner
  - Useful in adapting to dependent role

## Reactions to Illness/Injury

- Depression
  - Due to feelings of loss of control
  - Sadness, loneliness, apathy, low self-esteem
  - Countered by purposeful activity

## Reactions to Illness/Injury

- Denial
  - “Only a Little” problem
  - Inaccurate or incomplete history

## Reactions to Illness/Injury

- Displacement
  - Transferring one’s emotions to another
  - “Do something”, “It’s your fault”
  - Can cause anger, incomplete care by paramedic

## Reactions to Illness/Injury

- Confusion/Disorientation
  - Common in geriatric patients

## Behavioral Emergency

- Behavior which is so unusual, bizarre, threatening, or dangerous that it
  - Alarms the patient or another person
  - Requires intervention of EMS or mental health personnel

## Behavioral Emergency

- Interferes with core life functions
- Poses a threat to life or well-being of patient or others
- Significantly deviates from social expectations and norms

## Biological (Organic) Causes

- Dementia
- Substance abuse
- Drug withdrawal
- Head injury
- Hypoglycemia
- Infections
- Hypoxia
- Electrolyte imbalances
- Seizure disorders
- Cerebral ischemia
- Shock

## Psychosocial Causes

- May be related to:
  - Patient's personality style
  - Dynamics of unresolved conflicts
  - Patient's crisis management, coping mechanisms
- Heavily  influenced by environment

## Sociocultural Causes

- Related to patient's actions, interactions within society
  - Relationships, social support systems
  - Being victimized or witnessing victimization
  - Death of a loved one
  - Wars, riots
  - Loss of job
  - Poverty
  - Loss of a loved one
  - Ongoing prejudice or discrimination

# Assessment of Behavioral Emergencies

## Scene Size-Up

- Approach cautiously
- If it's bad enough to call EMS, it's usually bad enough to need the police
- Stay alert for signs of aggression
- Most patients with behavioral emergencies will NOT be a threat

## Initial Assessment

- Is there a life-threatening cause or concurrent medical emergency?
- Control the scene
- Remove people who agitate patient
- Observe patient posture, hand gestures, mental status, affect

## History/Physical Exam

- Rule out organic causes first
- Avoid lengthy attempts at detailed counseling, psychiatric diagnosis
- Be calm, look comfortable; patient usually is afraid of losing control
- Be patient

## Psychiatric Emergencies

- Be interested; get patient to talk
  - Open-ended questions “What, How, When”
  - Facilitate responses - “Go on” “I see”
  - May not be effective with adolescents, depressed, confused, disoriented patients
- Do not fear silence

## Psychiatric Emergencies

- Be nonjudgmental; do not criticize patient’s behavior
- Respect patient as a person
  - Ask relatives-bystanders to leave
  - Do not tower over the patient; sit down
  - Maintain a safe, proper distance
- Be reassuring

## Psychiatric Emergencies

- Be direct; especially with “scattered” patients
  - Be clear about expectations
  - Provide definite action plan
  - Use confrontation; “you seem very sad.. , etc.”

## Psychiatric Emergencies

- Encourage purposeful activity
- Let patient do as much for self as possible

## Psychiatric Emergencies

- Stay with patient
- Never threaten
- Never lie
- Never assume you cannot talk to a patient until you try

## Mental Status Assessment

## General Appearance

- Posture
- Personal hygiene
- Grooming, dress
- Facial expressions
- Body language/mannerisms

## Speech

- Tone
- Rate
- Volume
- Quality
- Quantity
- Changes during conversation

## Orientation

- Does patient know:
  - Who he is?
  - Who others are?
- Is he oriented to current events?
- Can he concentrate, answer questions?

## Memory

- Long term?
- Short term?

## Sensorium

- Is patient focused?
- Paying attention?
- What is level of awareness?

## Perceptual Processes, Thought Content

- Logic, coherence
- Delusions, hallucinations
- Homicidal, suicidal thoughts

**Do NOT be afraid to ask specific, leading questions**

## Mood/Affect

- Appropriate to situation?
- Signs of anxiety, depression?

## Intelligence

- Oriented to surroundings?
- Memory good?
- Capable of concentrating?

## Insight

- Does he:
  - Recognize there is a problem?
  - Have insight into it?
  - Understand why others are concerned
  - Blame others?

## Judgment

- Decisions based on sound, reasonable judgments?
- Problems approached thoughtfully, carefully, rationally?

## Psychomotor Behavior

- Unusual posture?
- Unusual movements?

## Specific Disorders

## Cognitive Disorders

- Delirium
  - Rapid onset (hours to days) of widespread disorganized thought
  - Confusion, inattention, memory impairment, disorientation, clouding of consciousness
  - Frequently associated with underlying organic cause
  - Often reversible

## Cognitive Disorders

- Dementia
  - Gradual onset
  - Memory impairment associated with:
    - Aphasia (inability to communicate)
    - Apraxia (inability to carry out motor activity)
    - Agnosia (failure to recognize objects, stimuli)
    - Disturbance in executive function (inability to plan, organize, sequence)

## Cognitive Disorders

- Dementia
  - Causes include
    - Alzheimer's disease
    - Vascular problems
    - AIDS
    - Head trauma
    - Parkinson's disease
    - Substance abuse
  - Typically irreversible

## Schizophrenia

- Affects about 1% of population
- Symptoms include
  - Delusions
  - Hallucinations
  - Disorganized speech
  - Disorganized or catatonic behavior
  - Flat affect
- Symptoms must cause social or occupational dysfunction

## Schizophrenia

- Major types
  - Paranoid
  - Disorganized
  - Catatonic
  - Undifferentiated

## Anxiety Disorders

## Anxiety Disorders

- Panic attacks
- Phobias
- Post-traumatic Stress Syndrome

## Panic Attack

- Exaggerated feeling of apprehension, uncertainty, fear
- Patient becomes increasingly “scattered”, less able to concentrate
- Usually peaks in 10 minutes, resolves in less than one hour

# Panic Attack

Signs and Symptoms

- Tachycardia
- Palpitations
- Sweating
- Trembling
- Shortness of breath
- Choking sensation
- Chest pain
- Chills or hot flashes
- Nausea, abdominal pain
- Dizziness
- Derealization, depersonalization
- Fear of losing control
- Fear of dying
- Paresthesias

# Panic Attack

- Management
  - Rule out organic causes
  - Remove panicky bystanders
  - Provide structure, support
  - Consider use of
    - Benzodiazepines
    - Antihistamines (hydoxyzine, diphenhydramine)

## Phobias

- Anxiety triggered by specific stimuli, situations
- Most common (60%) is agoraphobia, fear of open places

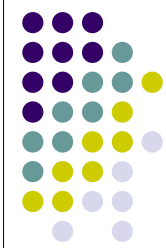
## Phobias

- Management
  - Provide structure
  - Let patient know what is going to happen, what you are going to do
  - Accept patient's fears as real
  - Do not tell them it is "all in their head"

## Post-traumatic Stress Syndrome

- Reaction to life-threatening event outside of range of normal human experience
- Symptoms include:
  - Fear of reoccurrence,
  - Recurrent intrusive thoughts
  - Depressions
  - Sleep disturbance
  - Nightmares
  - Persistent increased arousal

## Mood Disorders



## Depression

- Most common psychiatric disorder (10 to 15% of population)
- Tends to follow stressful events in persons who feel hopeless or who expect rejection
- Hereditary factors involved

## Depression

- Signs and Symptoms
  - Depressed mood most of day, every day
  - Diminished interest in pleasure
  - Significant weight loss or gain (>5%)
  - Insomnia or hypersomnia
  - Psychomotor agitation or retardation
  - Feelings of worthlessness, guilt
  - Inability to think, concentrate, decide
  - Recurrent thoughts of death, suicide

## Depression

***"In Sad Cages"***

- Interest
- Sleep
- Appetite
- Depressed
- Concentration
- Activity
- Guilt
- Energy
- Suicide

## Depression

Primary Danger = Suicide

Question every depressed patient about suicidal thoughts

# Depression

Depression is manageable

All depressives who do not commit suicide eventually recover

# Depression

## Management

- Take your time
- Show respect
- Avoid being judgmental
- Give patient opportunity to express feelings in private
- Do not be afraid to ask about suicidal thoughts
- Let patient make simple choices, perform simple non-competitive tasks

## Bipolar Disorder

- Periods of elation (manic episodes) with or without alternating periods of depression
- Affects <1% of population
- Onset usually in adolescence or early adulthood
- Males > Females

## Bipolar Disorder

- Signs and Symptoms
  - Inflated self-esteem; grandiosity
  - Decreased need for sleep
  - Talkativeness
  - Distractibility
  - Increase in goal directed activity
  - Psychomotor agitation
  - Excessive involvement in risky pleasurable activity
  - Delusional thoughts

## Bipolar Disorder

- Patients frequently have several depressive episodes before having manic episode
- Some patients with major clinical depression eventually develop bipolar disorder

## Bipolar Disorder

- Management
  - Calm, protective environment
  - No confrontations
  - Rule out organic causes
  - Do not leave patient alone
  - Use of antipsychotic medication may be necessary

# Somatoform Disorders

Physical symptoms, no physiological causes

## Somatoform Disorders

- Somatization disorder: Preoccupation with physical symptoms
- Conversion disorder: Loss of function (paralysis, blindness) with no organic cause
- Hypochondriasis: Exaggerated interpretation of physical symptoms as serious illness
- Body dysmorphic disorder: Patient believes he/she has defect in physical appearance
- Pain disorder: Pain unexplained by organic condition

# Somatoform Disorders

Always rule out possibility of organic illness!

## Factitious Disorders

- Intentional production of physical or psychological signs or symptoms
- Motivation is to assume “sick role”
- External incentives exist
- Males > Females
- Patients may have extensive knowledge of disease, terminology
- May become demanding, disruptive

## Factitious Disorders

- Munchausen Syndrome
- Munchausen by Proxy Syndrome

## Dissociative Disorders

- Individual avoids stress by dissociating from core personality
- Permits person to deny responsibility for unacceptable behavior

## Dissociative Disorders

- Psychogenic amnesia: Failure (not inability) to recall or identify past events
- Fugue state: Use of physical flight as a defense mechanism
- Multiple personality disorder: >2 complete personality systems in one person
- Depersonalization: Loss of sense of self; feeling of detachment from one's self

## Eating Disorders

- Generally develop between onset of adolescence and age 25
- Females > Males by 20x

## Eating Disorders

- Anorexia nervosa
  - Intense fear of obesity
  - Frequently believe they are “overweight” even when they are seriously underweight
  - Leads to excessive fasting
  - Results in ≥25% weight loss

## Eating Disorders

- Bulemia nervosa
  - Uncontrollable binge eating
  - Compensatory self-induced vomiting or diarrhea, excessive exercise, dieting
  - Patient’s fully aware of abnormal behavior
  - Frequently perfectionistic with low self-esteem, social withdrawal

## Eating Disorders

- Result in:
  - Malnutrition
  - Dehydration
  - Anemia
  - Vitamin deficiencies
  - Hypoglycemia
  - Cardiovascular disorders

## Personality Disorders

- Cluster A (odd, eccentric)
  - Paranoid personality: distrust, suspiciousness
  - Schizoid personality: detachment from social relationships
  - Schizotypal personality: acute discomfort in close relationships, cognitive distortions, eccentric behavior

## Personality Disorders

- Cluster B (dramatic, emotional, fearful)
  - Antisocial personality: disregard for rights of others
  - Borderline personality: instability in interpersonal relationships and self-image; impulsivity
  - Histrionic personality: excessive emotion and attention seeking
  - Narcissistic personality: grandiosity, need for admiration, lack of empathy

## Personality Disorders

- Cluster C (anxious, fearful)
  - Avoidant personality: social inhibition, feelings of inadequacy, hypersensitivity to criticism
  - Dependent personality: submissive, clinging behavior; excessive need to be cared for
  - Obsessive-compulsive personality: preoccupation with orderliness, perfection, control

# Impulse Control Disorders

- Kleptomania: stealing objects not for immediate use or monetary value
- Pyromania: setting fires
- Pathological gambling: preoccupation with gambling and urge to gamble
- Trichotillomania: pulling out one's own hair
- Intermittent explosive disorder: paroxysmal episodes of loss of control of aggressive responses

# Suicide/Suicidal Behavior

## Suicide

- 9th leading cause of death
- 3rd leading cause in 15-24 year olds

## Motivations

- Communication of hopelessness
- Communication of anger
- Manipulation of relationships

# Suicide/Suicidal Behavior

Motivation is difficult to judge!

Take all suicide acts seriously!

## Suicide Risk Assessment

- Women more likely to attempt
- Men more likely to succeed

## Suicide Risk Assessment

- Previous attempt (80% of those who succeed)
- Depression (500x more common)
- Presence of psychosis with depression
- Age (15-24 year olds; persons >40)
- Alcohol, drug abuse
- Widowed, divorced (5x rate in other groups)

## Suicide Risk Assessment

- Few social ties, no immediate family, unemployed
- Major separation trauma
- Major physical stress
- Loss of independence
- Lack of goals
- Giving away cherished belongings
- Family history of suicide (especially of the same gender parent)

# Suicide/Suicidal Behavior

The more specific the plan or the more lethal means selected, the greater the risk

## Suicide Management

- Dispatcher should keep patient on line, keep them talking
- Make contact with patient ASAP
  - Breaking in may be necessary
  - Avoid breaking in if patient is willing to talk through barrier

## Suicide Management

- Discretely remove objects patient could use to harm themselves
- Consider armed individuals homicidal as well as suicidal
- Medical management takes priority

## Suicide Management

- Communication must be open, clear
- Use patient's name frequently
- Remind them of their identity

## Suicide Management

- Do not be afraid to ask about suicidal thoughts, plans
- Consider aspects of patient's life that may provide resources for support
- Emphasize alternatives, constructive action

## Suicide: Management

- Never leave patient alone
- Take every attempt seriously
- Physician evaluation essential

# Angry/Violent Patients

## Angry/Violent Patients

- Can be response to feeling of helplessness, loss of control
- May be response to injury/illness

## Angry/Violent Patients

- Do not respond with anger
  - Let patient know you are there to help
  - Let them know you will not let them hurt anyone else
  - Explain what you expect from them
  - Ask them what they are angry about

## Angry/Violent Patients

- Do not try to subdue patient
- Involve police
- Do not threaten
- Do not bargain once restrained
- In ambulance, position yourself between patient and doors

## Avoiding Injury

- Safe distance
- Do not allow patient to block exit
- Keep furniture between you, patient
- Avoid threatening statements
- Respect personal space
- Adequate distance from partner

## Avoiding Injury

- Protection against thrown objects
  - Folded blanket over arm with foot holding blanket to floor
  - Hold blanket away from body
  - Same blanket can be used to wrap patient

## Methods of Restraint

- Goals
  - Restrict patient movement
  - Stop dangerous behaviors
  - Prevent injury to patient, others

## Methods of Restraint

- Basic Principles
  - Minimum force necessary
  - Appropriate devices
  - Non-punitive
  - Careful monitoring after restraint accomplished

## Methods of Restraint

- If you say you will, you must
- One person per extremity
- Approach from all sides at once

## Methods of Restraint

- Soft restraints
  - Prone position
  - One arm at side
  - One arm above head
  - Strap directly across lumbar region
- Do not hobble, hog-tie patients
- Monitor closely (positional asphyxia)

## Methods of Restraint

- Chemical restraints
  - Haloperidol, chlorpromazine
  - Last resort
  - Rarely necessary
  - “Don’t swat a fly with a shotgun.”
  - Consider medications patient may have ingested
  - Be prepared to manage EPS reactions